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SKIN DISEASES.

1. The commonest skin diseases to be expected in the Army of Occupation are scabies, impetigo, ringworm, and the various dermatophytoses. Early diagnosis and properly administered adequate therapy will prevent unnecessary hospitalization and diminish the non-effective time of the patient. A pertinent review of the diagnostic signs and symptoms is presented here for review. The currently accepted therapy and therapeutic suggestions follow the description of each disease.

2. Diseases.

a. Scabies.

(1) The diagnosis is suggested by pruritis of increasing severity. The nocturnal accentuation of the itching is a common complaint. Pruritis may be localized to the pubic and genital regions in mild and early cases. It may extend to all parts of the body, most characteristically on the upper thighs and buttocks, lower abdomen, anterior axillary spaces, finger webs and flexor surfaces of the wrists and forearms.

(2) The characteristic lesion is an excoriated or crusty papule. The papules are frequently paired and may be communicated by a barely visible dark furrow. A small single translucent vesicle in the finger webs or on the wrist is almost diagnostic. The penile and scrotal lesions are larger papules and darker red in color. There is usually a concomitant eczema. The diagnosis is confirmed by examining scrapings of the lesions under the microscope and finding the mite.

(3) Treatment of choice is with benzyl benzoate If this agent is not available then sulphur ointment USP can be used.

(4) Benzyl Benzoate Therapy. The patient should be instructed to take a complete hot bath with frequent complete soapings. Following the cleansing, a

10% to 25% benzyl benzoate preparation is applied covering every spot of the skin surface from the hairline on the neck to the soles of the feet. Meticulous attention should be paid to that surface under the foreskin and in the folds of the groin (in the case of the female, the external labia). Help is required in ensuring adequate application to the surface of the back. It must be emphasized that frequency of failure of therapy will increase if any part of the skin surface is missed in the application of this drug. On the second night the drug is reapplied in the same manner with the same precautions. No bath should be taken in the interim. The morning after the second application a hot bath with complete cleansing of the skin must be carried out. Following this cleansing bath, clean clothing should be put on. The old clothing must be sent for cleansing. Blankets, wherever possible, should be aired and cleaned. An eruption will persist for approximately one week. A bland ointment such as simple boric acid, should be used daily during this time.

(5) Sulphur ointment therapy. After a complete bath of hot water and soap, sulphur ointment is liberally applied to the entire surface of the body from the hairline of the neck to the tips of the toes. When available, long woolen underwear covering the arms and the legs should be worn. Without bathing, sulphur ointment is reapplied on the second and the third evenings. The same long underwear or pajamas are worn continuously day and night for these three days. At the end of the third day, a thoroughly cleansing hot bath is taken. The underwear or pajamas are discarded and clean clothes put on. Blankets should be aired and cleansed whenever possible. The sulphur ointment has a tendency to produce extensive dermatitis. The patient should be warned against this possibility and the application of the ointment stopped immediately and residual ointment thoroughly washed off the body if this occurs.

(6) If treatment failure is suspected by persistent symptomatology, the patient should be referred to a hospital for further therapy.

b. Pyoderma.

(1) Pyoderma occurs either as a primary infection commonly on the bearded region of the face or other hairy portions of the body. Under this category

is included the diagnosis of impetigo, pustular folliculitis, sycosis barbae. Secondary pyoderma is due to infection superimposed upon a dermatitis commonly from scabetic therapy. The danger from pyoderma lies in the secondary cellulitis and lymphangitis.

(2) Therapy in simple uncomplicated cases consists in the application of warm boric acid compresses or soaks for half an hour at least twice daily. Following at least one of the soaks and compresses the thick softened crusts should be removed mechanically. 5% sulfadiazine ointment should be applied liberally after each of the compresses or soaks. If at the end of one week the lesions still persist or if sulfadiazine ointment is not available originally, then an ammoniated mercury ointment should be used. The strength of this ointment can be from 3% to 5%. The sulfa drugs are not indicated for oral therapy unless there is indication of cellulitis or lymphangitis. Penicillin therapy is ordinarily not practical in unit dispensaries. The commonest organism involved is a staphylococcus which is not sensitive to this agent.

The use of the dyes, such as gentian violet, metaphen or merthiolate, solutions of silver nitrate or Whitfields ointment, are not indicated in the routine treatment of pyoderma.

c. Dermatophytosis.

(1) Severe dermatophytosis is infrequently seen in this theater. When present it is usually secondary to infrequent washing of feet with soap and water, or excessive perspiration. Excessive interdigital maceration and/or vesiculation of toes or soles are the commonest manifestations. Hypertrophic, lichenfied and scaly plaques are more rarely encountered. Pustulation is not an integral component of dermatophytosis; when seen it is indicative of secondary pyoderma, and should be managed as such. If neglected, swelling of the toes, secondary cellulitis and at times lymphangitis frequently supervene, and hospitalization becomes necessary.

(2) Treatment of uncomplicated dermatophytoses. The macerated type may be treated with an ointment containing 5% ammoniated mercury and 2% salicylic acid at night and a bland dusting powder by day. 2% aqueous solution of gentian violet may be substituted for the

ammoniated mercury. 2% salicylated alcohol is useful to ensure permanency of results. Acute vesicular dermatophytosis should be treated as a dermatitis with boric acid or permanganate soaks. A soothing zinc oxide ointment or Lassar's paste is then applied. During convalescence a bland dusting powder may be used. The hyperkeratotic type of dermatophytosis may be treated with 5% ammoniated mercury and 2% salicylic acid ointment. If resistant, 2% to 3% tar ointment is of value.

All patients with chronic recurring dermatophytosis should be given instructions regarding foot cleanliness, with daily soap and water washing, the use of foot powder, and cotton socks. Whitfield's ointment is not recommended as a routine treatment for any form of dermatophytosis, except as specifically prescribed by a dermatologist.

d. Dermatophyte.

When dermatophytosis of the feet is complicated by vesiculation of the fingers or hands, a diagnosis of dermatophyte may be made. This should be treated not as a dermatophytosis, but as an acute dermatitis, using continuous boric acid compresses followed by zinc oxide ointment when mild and subacute. Secondary infection should be managed as above outlined.

c. Tinea Cruris.

Tinea cruris may be controlled by the use of potassium permanganate soaks, followed by 5% ammoniated mercury and 2% salicylic acid ointment, or by the following ointment:

Sulphur PPT	0.5%
Sol. coal tar	0.2%
Salicylic acid	2.0%
Lanolin	10.0%
Benzoinated lard	q.s

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